



**Advisory Committee to the Director  
Centers for Disease Control and Prevention (CDC)  
Holiday Inn Select/Decatur Hotel  
Decatur, Georgia**

**MEETING SUMMARY  
August 5, 2004**



**Department of Health and Human Services  
Public Health Service**

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**Centers for Disease Control and Prevention  
Advisory Committee to the Director**

**Summary Minutes of the August 5, 2004 Meeting**

A meeting of the Advisory Committee to the Director (ACD) of the Centers for Disease Control and Prevention (CDC) was held on August 5, 2004, at the Holiday Inn Select/Decatur Hotel, Decatur, Georgia. The meeting was convened by Executive Secretary Mr. Robert Delaney. Chair Dr. John O. Agwunobi welcomed the members and other attendees, who are listed on Attachment.

**AGENDA**

**CDC Director's Update**

**An Update by the CDC Director was provided. Dr. Julie Gerberding cited CDC's challenge of providing evidence-based public health policies, programs, and practices that promote safer, healthier people in all communities. To achieve this, CDC pursues the highest standards of excellence in science, service, strategy, and systems that support these activities.**

CDC's new *strategic imperatives* fall under the categories of maximizing the health impact of CDC's work, by aligning its strategy, goals, and performance; focusing on its customers, by marketing what people want and need to choose health; conducting the kind of public health research that produces real health impact; and providing leadership, leveraging CDC's unique capabilities to improve the health system

*Excellence in systems* includes vigorous performance measurement for improvement relative to accountability, efficiency, and effectiveness. Key performance indicators (KPI) provide a quantifiable target to measure results, define optimal levels of performance, and track achievement toward those levels. Global biosurveillance is being conducted with the International Health Protection Network. Other related activities planned from FY04 through FY06 are being done under the aegis of the Global Health Protection network, the Laboratory Response Network [LRN], and the International Health Protection Network, as well as through the real-time surveillance and pooled data capacities of the BioSense Project and the Biointelligence Center.

*Excellence in strategy* is reflected in the conduct of leadership workshops that involved more than 400 CDC leaders. The Futures Initiative immersion continues, focusing on improvements in goals management, health marketing, and business services. External direction and insight on critical Futures issues was solicited and received. New proposals were fielded to advance health

equity, which involve resource allocations and accountability measures and external input.

*Excellence in service* was demonstrated by extensive personal outreach by the Director, improved internal and external communication and outbreak prevention/response activity

*Excellence in science* is reflected in the agency's expanded research focus. CDC has issued its first RO1 awards (for worksite health promotion/intervention research) and KO1 awards (for public health research career development, again in worksite health promotion). Grants were issued to fund a Health Promotion Economics Center of Excellence (to conduct economic research pertaining to employer-based health promotion), as well as T-Grants (institutional fellowship training grants for public health research). CDC's goal-directed, prioritized and targeted research agenda is integrated with NIH and other agencies, taken through peer-review and followed to health impact.

Participatory community-based research includes work to address disparities in health screening, improve food choices among school children, increase the time to the sexual debut of adolescents, promote early detection of autism, and communicate health messages to youth. This participatory research is designed to translate new knowledge to "best practices" that are then delivered to targeted and new populations.

The activities for which the Director is accountable and responsible were outlined. She is *accountable* to ensure the maintenance of high standards and policies. Beyond that, she must ensure that CDC's performance and progress are measured, reported, and improved, and that all CDC staff can work in an environment supportive of success. She is accountable for the proper stewardship of CDC's resources, and for sustaining its credibility and core values.

She is *responsible* for contributing to the development and successful execution of DHHS strategies and policies; communicating CDC's strategies, issues, performance, and needs to the Secretary and his designees; articulating CDC's strategic vision and goals; leading CDC's Executive Leadership Board (ELB) and assessing and supporting its members; communicating as a CDC spokesperson and representative; and articulating and enforcing standards of ethical, equitable, and respectful conduct in all CDC's enterprises. The Director's deliverables for FY05 are to define CDC's strategic framework and goals, develop the annual health protection impact report, conduct an annual appraisal of customer and employee satisfaction; and conduct a semiannual ELB member performance improvement review and a monthly CDC goal performance summary.

CDC's new *strategic imperatives* are: to maximize the health impact of CDC's work, by aligning its strategy, goals, and performance; to focus on its customers, by marketing what people want and need to choose health; to conduct the kind of public health research that produces real health impact; and to provide leadership, leveraging CDC's unique capabilities to improve the health

system.

Some of CDC's successful work was outlined according to the life stages approach suggested by the committee at its last meeting: Infants (decrease in neural tube defects due to the folic acid campaign, 10<sup>th</sup> year of declines in congenital syphilis, HIV testing delivered to millions of pregnant women to protect them and their newborns); Children (80% decline in pneumococcal disease among children aged <2 years; 34% increase in physical activity by children aged 9-10 years due to VERB campaign outreach); and Teens (7% rate increase in reported sexual abstinence, 17% increased use of condom protection; decrease to <25% of cigarette smoking).

*Discussion* with Dr. Gerberding included:

- As congressionally earmarked funding becomes more nondiscretionary for CDC's use in areas of most need, public engagement in the priority setting process will be important to the transparency of this process. *Response:* CDC's Futures Workgroup also stressed the latter, and relevant CDC models already in use include NIOSH's occupational research agenda (NORA). Public involvement will include not only input to the agenda setting process, but also extend to participatory research.
- Goal management involves a dynamic between ensuring a maximum benefit to the nation's health as well as the core public health functions. While the latter work may benefit far fewer citizens, it may reflect the areas of most need and it is unlikely to be done by any other entity. *Response:* Agreed. The process of the Office of Public Health Improvement involves CDC's balance between the infrastructure, public health leadership and special responsibilities. CDC uses a loose "80/20" guideline, in which 80% of its work involves accountability and preparedness/health impact, while maintaining the 20% of the small, lesser-visibility programs (e.g., rabies control).
- *Will the Coordinating Centers be "Super Centers"?* CDC's organizational structure is established, but the assignment of specific activities within the structure is ongoing. The main focus of the Coordinating Centers is to identify opportunities for integration and synergy between the organizational clusters (each of which also will have new senior executive staff in place by October 29) and to improve the Centers' overall management and accountability.
- CDC's credibility rests on the unbiased excellence of its science and as little involvement in the political process as possible until a policy decision is made. *Response:* Related to this is not only Capitol politics, but bias that can be science-based or not. The real goal is objectivity in assessing the evidence that supports the policy advice provided to the Executive branch. There is no hard-and-fast metric for such objectivity, but the integrity of CDC and its leadership rests on its ability to speak up when it is hazarded. The "evidence" often used to politicize science is usually very poorly founded in fact. Each instance of discussion also be examined in context, particularly the "hot" topics involving sex, guns, abortion and stem cell research. For example, CDC's closure of its Condom Website caused alarm, but that was done to update it and remain consistent with the new

science of the NIH's new Condom Report. The Director was invited to bring such controversies to the committee for their input and help.

- As well as the factor of personal responsibility involved in the obesity epidemic, environmental factors also demand attention. *Response:* Those are only two of many contributing factors. CDC's contribution is to supply the information to help individuals and communities make the best choices for their health. Some debate on this, both within and with external partners, will be welcomed as CDC tries to find solutions. What is posted on the Website will be supported by the evidence. But in some cases, it is not the science involved, but the questions chosen to be asked, that may reflect bias or politics involved. The fact that CDC is part of the Executive branch and the reality of many gray areas when crafting policy challenges the CDC Director's efforts to maintain an unbiased image with the public. Dr. Gerberding's outreach to the agency's consumers, the public, and to Congress has been helpful and was commended by the committee.
- The Director asked the members' interest in participating in a subcommittee to bring back to the full committee specific, detailed advice on particular issues for the Director's benefit. Several members welcomed the opportunity to be more engaged. One suggested that committee members be notified when Dr. Gerberding visits their area (e.g., to inform her of local opinion leaders, to visit the local health department with her, etc.). *Mr. Delaney was asked to gather, by the next meeting, information on models that this committee could use to more intensively gather and review information with which to assist CDC.*
- The committee's role in addressing tobacco-related issues was inquired. Many of the states have used the tobacco settlement funds to support state budgets, and there are little data on the success of interventions that were funded from the settlement. Dr. McIlhaney noted the remaining contribution of tobacco use to the nation's health outcomes, and the need to further reduce smoking prevalence. California successfully used these funds to reduce smoking prevalence to 16%, but the temptation to divert those funds to other uses was too strong in other states that received huge settlements. "Money talks" on both sides: the industry spent \$11.2 billion to market its product last year, and that increased pace has to be met. The expectation is that, when the prevention funding ends, the smoking rates will rise again. Sustained funding is a very important component of public policy. This is a very complex area to address without producing a backlash. *Response:* Drawing attention to this very important health issue would be very appropriate. *A more detailed briefing of the related issues could be provided by CDC to the committee.* This issue affects every life stage. The final product of those developing the evidence base of the goals management/process will include policy as well as research and programs. *The Board's review of the tobacco action plans will be welcomed* and other convening or communication actions (e.g., a Board recommendation of CDC actions on these issues) could be appropriate. *A briefing by conference call could be scheduled in the next few weeks.*

**Presentations provided included:**

***Pilot Project to Improve CDC Services to States***

Presenter: Mr. Joseph M. Henderson, CDC Senior Management Official (SMO) to New York State

Seventy-five percent of CDC's budget (\$5.2 billion) is awarded annually to outside agencies in grants, contracts, cooperative agreements, and interagency memoranda. These address infectious and chronic disease control, injury control, environmental and employee health and safety, emergency public health preparedness and response, and other public health prevention activities. The dispersal of that funding through ~22 different Centers, Offices, and Institutes (CIOs), created a "silo" organizational process at CDC. This in turn produced inconsistent program directions and interpretations of policies, rules, and regulations. The programmatic focus (rather than health or communities overall) of the funding's performance requirements prevented flexibility in the work and confounded good measurement of the program and its fiscal effectiveness.

A pilot project to be done January 1, 2005 to January 1, 2007 was begun to: 1) make CDC's business services to these funded state and local programs more efficient; 2) provide leadership to improve coordination of all CDC-assigned field staff; and 3) ensure the effective delivery of requested CDC technical assistance. To do so, CDC Senior Management Officials (SMO, or "portfolio managers") will be assigned to the states receiving most of the funding to improve the management of grants and CDC field staff.

The pilot was approved by CDC's Executive Leadership Board and the Director in June 2004 and in July a supervisory subcommittee was formed with the ASTHO Deputies Committee. A senior CDC workgroup will guide the project. Mr. Henderson was the first CDC SMO official assigned, to New York state, in July. Five to eight such individuals will be hired.

As their role is envisioned, the SMOs will: 1) serve as the senior entry point for health officials to access and improve CDC program and business services; 2) oversee/assist to solve problems related to the CDC grant programs; 3) provide "high-level" oversight of and support to all CDC assigned staff; 4) serve as the lead in-state CDC official to support state and local public health emergencies; and 5) represent CDC and the state to the media when deemed necessary. They will 6) support the development and implementation of public health laws, rules, and regulations and 7) improve the strategic decision-making associated with CDC funded programs

To do the latter, an annual public health performance plan will be developed to provide a comprehensive understanding of progress being made relevant to health impact. The plan will align with the current CDC Health Protection Goals. Specific pilot outcomes listed were to: assure that CDC-funded projects impact health in line with higher-level strategic goals; identify

funding needs; improve program management efficiencies; provide a communication tool to convey CDC-funded program progress to state and federal legislatures; support program authorization and fiscal appropriation; and provide a strategic management tool for senior state and CDC officials to support policy and decision making. In New York, the CDC State Health Profiles Report ([www.cdc.gov/epo/shp/index.htm](http://www.cdc.gov/epo/shp/index.htm)) may be used as the platform to launch the state performance plan. New York state's public health organization, CDC funding (~\$350 million) and CDC-assigned staff (56) were outlined, as was the time line for the preparatory steps to launch this pilot by January 2, 2005.

### ***Goals Management Pilot Project***

Presenter: Mr. Brad Perkins, CDC Goals Manager

CDC's goal management is a continuous process in which evidence, input, CDC mission, feasibility and impact factor in the formation of CDC goals. These are delineated by life-stage and then described in an evidence-based action plan. The latter details the related accountability and responsibility in assignments and resource allocation. Performance measurement then reveals whether the maximal impact was achieved, both in the short- and long-terms.

A pilot project was begun in June 2004, to: 1) develop processes and systems for agency-wide goals management; 2) identify, implement, and communicate early low-cost "wins" (e.g., creatively bundling existing programs or leveraging existing partnerships); and 3) plan for full implementation of goals management by April 2005, to support the fiscal year 2007 (FY07) budget process. Community preparedness and two life stages (adolescents and adults) will be the focus. The preparedness will take advantage of the bioterrorism infrastructure available, and the life stages will use the good data available on the range of disease burdens and health issues and issues of related sectors (by public health, education, health care, and business).

*Structure.* Three pilot teams of 8-11 people will be staffed by full-time team leaders and liaisons assigned to the Office of Strategy and Innovation (OSI), and by part-time (50%) CDC staff details. The OSI will provide the core support in analytics, IT, budget, and policy.

A standard analytic framework created by life stage goals will: 1) establish a baseline health status using quantifiable and comparable measures; 2) assess the state of the science; 3) assess the cost-effectiveness, according to the percent of target population reached and current CDC investment levels; 4) identify gaps (science, investment, sectoral barriers); and 5) prioritize opportunities. One pilot being spontaneously developed by CDC staff contacted by Mr. Perkins will use this framework to analyze the issues related to pre-term birth.

### *Health Marketing*

Presenter: Dr. James S. Marks, Director, Coordinating Center for Health Information and Service (CoCHIS)

Sited within the Coordinating Center for Health Information and Service are the National Centers for Health Marketing, Public Health Informatics, and Health Statistics. The Coordinating Center is being built from existing CDC units: the Office of Communication, selected activities and divisions of the Public Health Practice and Program Office, and selected offices, divisions, and programs of the Epidemiology Program Office.

The intent of this Coordinating Center is to have CDC be more available to the public as a source of useful information and to actually “market” health by providing the information needed for better decision-making. Marketing is a proven public health intervention. It focuses on behavior change for health impact, including supportive policies and environmental change. It positions health not as the ultimate outcome, but as a facilitator for things people really value (e.g., energy, independence, etc.). Health, across the life stages, gives life its potential, which makes health equity and the elimination of disparities critical. People view health as quality of life, not as the absence of disease. With the aging of the population, CDC’s challenge is to extend the years of healthy life and to reduce medical costs at life’s end.

Unlike clinical medicine, in which evidence of a proven intervention ensures its retention in the armamentarium of health tools, public health’s increasing evidence of effective interventions has not prevented an actual decline in its funding, even in affluent times. Additionally, the energy that promoted the synergy of preparedness to reinforcing the public health infrastructure is fading.

Public recognition is vitally needed of the value of such practical, proven public health adjuncts as sidewalks or physical education in school. Promoting that recognition is an important aspect of health marketing. One recent health marketing example was the successful VERB campaign, conducted to encourage physical activity by youth. It connected with the target audience’s (“tweens” aged 9-12 years) values to promote activity as a first choice with health hardly mentioned. Despite early success, its budget has not been able to be sustained.

CoCHIS’ strategic vision and priorities lead marketing and communications research to serve other CDC Centers. Its documentation of best practices contribute to embedded CDC programs. Its centralized services should ease the access of external partners, and its coordination function does the same for CDC’s customers. Its excellence in science is demonstrated by its ongoing research synthesis in the development of the *Guide to Community Preventive Services*, the public health companion to the *Clinical Guide*. Its economic research proves prevention effectiveness and provides input to health systems and policy research, showing how policies work, affect the nation’s economy, or the gaps that exist.

CoCHIS' marketing and communications research will factor in consumer insights (attitudes, fears, concerns, desires) and media influences (advertising, soap operas, prime-time TV, etc.). Its translation and dissemination research will explore how to put the science into actual practice. It expects to maximize connectivity through the Internet, and pursues fresh approaches to bring health as a personal issue to the public. For example, condensed and summarized information for the public can be electronically disseminated, perhaps through a pragmatic, opt-in newsletter that puts national and individual health into context. CDC has discussed reaching out to the public with other agencies that have effected it (e.g., NASA). Other approaches are needed that emphasize the connectedness of people, the concept of social capital, and the influence of major societal forces. Attention to population-based quality of life and the impact of disabilities on the activities of daily living also are needed.

Good communication to and from the public is a fundamental and critical need. However, the support provided to CDC to address acute and chronic disease has not been matched to get the needed information out.

When asked the difference between CDC's Informatics activity and the work of the National Center for Health Statistics, Dr. Marks explained that NCHS is the source of the metrics used to indicate whether or not progress is being made (e.g., vital statistics gathered in such surveys as NHANES). The NCPHI will not only receive such data and reports, but also reach out to make that information available to the public and the professional community. It will access clinical information more quickly than the previous 20-30-day lag that can exist (e.g., for an infectious disease report) while still protecting individuals' privacy.

### ***Increasing CDC's Impact on Health Equity***

Presenter: Dr. Walter Williams, Director, Office of Minority Health

The May 2004 CDC Futures Forum focused on health disparities as a continuing CDC priority. In a new, cross-cutting focus on health equity (defined by race, ethnicity, age, social status, gender, geography, SES and sexual orientation), CDC will expand the functions of the Office of Minority Health to create Office of Health Equity housed in the Office of Strategy and Innovation (OSI). The Office of Health Equity will link the health equity goals to the core functions of the OD staff offices and those of the Coordinating Centers, to help improve the health impact of CDC programs. The OSI's core functions (scanning, analysis, innovation, goals management, and "Team B" CDC-wide performance review) will be supplemented by the OHE's health equity focus. This emphasizes policy, intervention, and performance evaluation of programs to reduce health disparities.

The definition of "health equity" includes those things that are considered avoidable and unfair.

as well as the standard definition of inequality or difference in condition or rank. The policy implications of the definition extend to such situations as a disease or health condition which may affect relatively few in the population, but affect them disproportionately.

The current functions of the Office of Minority Health were outlined. OMH provides minority health priorities to strategic planning and policy initiatives (e.g., analysis, development), and leads/coordinates minority health initiatives and Executive Branch activities. It supports epidemiologic studies across CDC and provides subject expertise to external partners and throughout CDC. Much of its work is determined by Executive Orders to address the health issues of large ethnic populations (e.g., African-Americans, Latinos, Asian/Pacific Islanders, Native Americans/Alaska Natives). Work is accomplished through partnerships, collaboration, intergovernmental personnel actions and cooperative agreements. The Office also supports summer internships at CDC for students, in the hope of attracting them to a public health career.

The new cross-cutting focus defines health equity as 1) the absence of modifiable health disparities among the most vulnerable groups, and 2) the absence of avoidable and unfair differences/manifestations of good health and longevity. A list of seven determinants of disparities developed by Margaret Whitehead, which was adopted by the WHO, was shared.

The Office of Health Equity will continue to serve as the point of contact on health disparities and equity, collaborating with all the OD offices and the Coordinating Centers. Other important functions will be the translation of proven interventions into actual practice, coordination of Executive Branch activities and Secretarial initiatives, and serving as the principal advisor to the Director on health equity issues, especially those which are controversial or challenging. It will align CDC with national and international interests in equity goals, drive those goals through the management process, and engage the equity focus in CDC's performance management and accountability.

*Discussion included:*

- Dr. Benjamin appreciated that this office, with a budget of ~\$2 million, will influence the entire ~\$7 billion of CDC's overall budget. Extending the influence of such a small budget is a revolutionary and welcome new approach, and it knits the reduction of disparities to the fabric of every program.

***Public Health Research***

Presenter: Dr. Dixie Snider, Chief of Science, CDC

The guiding principals used in setting CDC's public health research agenda are: 1) to parallel that of the agency's overall health protection goals; and 2) to address the knowledge gaps in order to achieve those research goals. This includes not only maintaining, but encouraging,

innovation related to the unique CDC capabilities that contribute so much to national and global health, even if they do not support one of the agency's major health goals. A third guiding principal is to develop the research agenda with external input.

In FY04, CDC hopes to fund research Requests for Application (RFA) at ~\$30 million, in four areas:

1. Investigator initiated (R-01), focusing on the determinants affecting the successful implementation of innovative, cost-effective programs/activities in or affecting the work place.
2. Supervised career development experience (K-01) includes a variety of disciplines that involve public health research and will probably affect priority public health issues.
3. Institutional training (T-32) via awards to institutions to develop/enhance training opportunities for individuals likely to affect priority public health issues through their research. CDC cannot accomplish the nation's health goals alone; it will need the assistance and creativity of external researchers who might otherwise go into clinical research.

The K-01 and T-32 proposals resulted from strategies suggested in a meeting with partners (e.g., Research America, Association of the Schools of Public Health, AAMC, etc.), who listed several areas of health protection in particular need of attention:

- a. Etiology and needs: social, ecologic and developmental determinants of health; determinants of individual behaviors that impact health; assessing the impact of social trends on population health needs.
  - b. Prevention: Determinants of successful implementation of evidence-based interventions; reduction of health disparities; effectiveness of community-based interventions; application of genetic information to population health.
  - c. Methods and infrastructure: Impact of infrastructure and policy alternatives on health outcomes; economic factors and health; improved surveillance methods; early detection of public health risks; communication strategies; workforce needs and training issues.
4. Establishment of a Center for Excellence in Health Promotion Economics (P-30), to supplement the inadequate supply of public health economic researchers by developing institutional capacity in health promotion economics. The Center will explore economic barriers, priorities, solutions and potential impact (particularly that of cost effectiveness), of developing, evaluating and implementing health promotion guidelines, recommendations, policies and programs to prevent disease, injury and disability. That is, it will make the economic arguments that support public health interventions.

The RFAs address health protection through preparedness for infectious disease, environmental, or terrorism threats, and health protection through health promotion and prevention of disease, disability and injury, to provide the best possible life span and quality of life stage. To date, 199 applications have been received, more than can be funded. The processes of external and

internal peer review toward award were outlined; the awards are expected in September.

Dr. Frieden hoped that the R-01 program would fund research relevant to public health *practice*, building on CDC's expertise in applied epidemiology. Other funders will support research in other scientific areas. Dr. Snider reassured him that this is the intent.

Dr. Snider reported discussion about the functioning of the Office of Public Health Research, under the direction of Dr. Robert Spengler. Within the office of the Chief of Science, the OPHR will lead in developing the research agenda, while working closely with CDC's various goals management teams. An oversight or steering group is needed and could be provided by a subcommittee or workgroup of this advisory committee. This could be composed of committee members supplemented by research experts. Since the research agenda needs to be completed by May 2005, such steering committee and public input is needed soon.

### ***Buildings and Facilities***

Presenter: Mr. Edward (Chip) Stehmeyer, Director, Facilities Planning and Management Office

Mr. Stehmeyer, formerly of the Naval Facilities Engineering Command (28 years), outlined the CDC physical improvements that support the science.

*Roybal campus* construction underway includes the Emerging Infectious Diseases Lab; a new headquarters building and Emergency Operations Center; and a Global Communications facility that includes the Visitors/Education Center. All three are due to open in late summer 2005. An administrative building housing the Lifestyle program and the staff fitness center will open early, in December 2005, resulting in a savings of \$3.5 million due to earlier construction and rent saved. These projects all incorporate sustainable design principles by maximizing use of campus green spaces, optimizing energy efficiency, and day lighting inside the buildings.

*The East campus lab consolidation* (\$365 million project) will be completed in late 2008 or early 2009. This will consolidate all the older Roybal (and some of the Chamblee) biosafety level 3 and 4 labs into modern labs on the Roybal campus. An Epidemiology Office Tower will be completed on Roybal in the same time frame, and will consolidate that science staff. Building sites are reserved for two office buildings and another lab to address potential expansion beyond the present Roybal Campus Master Plan for 2009.

*Chamblee campus* construction underway includes the nearly complete Building 110, the Environmental Toxicology Lab. It should be complete and operational by early fall 2005. The completion of Building 106, a dry lab and administrative building that will house ~675 personnel now in leased spaces, has been accelerated by 12 months earlier than anticipated. Earlier

completion of Building 106 will save CDC approximately \$6.2 million

*The Fort Collins Vector Borne Disease Lab* will be operational by 2007. This houses work on such diseases as West Nile, Dengue fever, plague, etc. As such, if the Roybal campus infectious disease lab goes off line, this and the Ft. Collins lab could be used to continue operations as a primary lab for infectious diseases.

Dr. Gerberding gratefully acknowledged the support of the CDC advisory committee and the Centers' scientific counseling boards for the CDC master facilities plan. They were important contributors to gaining these critical new facilities. Also important were the "friends of CDC," including the CDC Foundation and prominent business leaders in the Atlanta area.

*Discussion included:*

- Dr. McIlhenny asked what members of Congress were particularly helpful in gaining this funding. Dr. Gerberding cited Chairman Regula, Congressman Obey and Senators Specter and Harkin as important champions of this process, along with the entire bipartisan Georgia delegation.
- Dr. Yancey asked if there were any demographic data on the staff who utilize the Lifestyle Center. Mr. Stehmeyer did not have the statistics on hand, but he had understood that it is under-utilized, being in a campus area difficult to access. The new facility will be better sited and equipped, not only for the staff, but to serve as a new technology demonstration facility for private industry.

### ***Business Service Improvements***

Presenter: Mr. James Seligman, CDC Chief Information Officer (for Chief Operating Officer Mr. William Gimson)

While business services are not a mission-direct activity, they do enable and support mission functions and can greatly facilitate them or do the contrary. CDC's initiative on business services improvement includes an intense focus on customer service, to enhance the health impact and achieve efficiencies to allow redeployment of resources to other mission direct areas of need. In the end, the goal is customer satisfaction with more responsiveness, more speed and agility without diminished quality, cost efficiency, or innovation.

We are trying to bring the same kind of traditional dedication to evidence-based, analytic rigor in science at CDC to the business services arena such as rigorously measuring processes and analyzing the underlying causes of why processes are not optimal. Both internal and external transparency is important in developing service agreements for all the processes, negotiating those with internal/external customers, continuously measuring the results, and publishing the key performance indicators monthly.

The five major components of the President's Management Agenda (PMA) were briefly shared, as was the most recent DIIIS "report card" for CDC.

1. **Strategic management of human capital.** CDC has a yellow score as this is still under development. An important aspect of this was the Secretary's initiative to reduce the number of staff in support positions, to reassign them to the front-line public health practice/research positions. This would involve 573 positions that would in some cases be reassigned, but in others, the position role would be redirected after attrition.
2. **Competitive sourcing.** This program establishes a competition between the government and the private sector for functions that are commercial in nature. Such work involves 43% of CDC's 9400 employees. Those positions will be methodically studied and competed over the next ten years, to determine which entity can carry out the function more cost effectively. OMB statistics indicate that the government is saving up to 15-25% through such private/public sector competition. CDC has met the 2002 and 2003 goals and will meet those for 2004. It was the first federal agency to develop an alternative to that competition, the "high performing organization," focused on its IT services. This is expected to save \$160 million over the next five years with no degradation in service.
3. **Improved financial performance.** Financial audits of the last 5-6 years have yielded a "clean opinion" and aggressive work has been done in the past two years to hire and train financial managers.
4. **Expanded "E-Gov."** CDC hotlines are being consolidated and outsourced with rigorous performance standards and expanded services such as 24 hours a day, 365 days a year access, multi-lingual, and hearing impaired services. CDC's website receives ~10 million visitors a month and double that amount during public health emergencies.
5. **Integrated budget and performance.** *Budget:* Among the steps to implement this is to have CDC's budget submissions to the White House and Congress in a performance base. The White House is studying all federal programs over a 5-year period, scoring every program with the Program Assessment Rating Tool (PART). Four of the five areas of CDC's FY05 budget submission were rated adequate. The one outlier involved a line item that spanned multiple CDC areas, which made tracking the funding, evidence and outcome difficult to measure. Other illustrations were in the meeting packet for the members' review.

**Performance measurement.** Illustrations of CDC's focus on business services performance measurement were given. The benchmark for hiring new employees was 92 days in 2003; the 50-day standard for 2004 is on track. That is being accomplished in part with the better use of information technology, despite a 30% reduction to the Human Resources staff. Statistics also showed that more than 500 staff have gone from support positions (e.g., human resource, IT or financial management) to front-line positions. The 7-month cycle time required to award a grant, cooperative agreement, or contract will be

reduced 15-20% without sacrificing quality, with the help of an outside business improvement consultant. Quality (as measured by first pass yield of a transaction through the process) is targeted to improve four- to five-fold. Other areas of excellence outlined included timely and correct financial payments, continuous growth of Website visitors, and increased personnel training.

*Discussion included:*

- Mr. Seligman reported the development of an online competency assessment and training catalog system integrated with each employee's position, that will identify the competencies required for each career track at various levels and how each incumbent employee matches against the standard. It then provides information on training courses needed to close any gaps.
- Dr. McIlhenny asked, and had confirmed, that "learning accounts" would be in place for every FTE as of next year. The authority to allow staff to carry that forward from year to year has not yet been authorized.
- Dr. Benjamin reported a current national effort to radically improve-increase the CDC budget, with the help of congressional champions. More on this will likely be heard in the coming year. Dr. Galli commented, however, that the FY05 budget was somewhat flat. Dr. Gerberding noted the prohibition against lobbying by federal employees. But CDC is now focusing on "selling success" to demonstrate the wisdom of investment in prevention, which is hoped to attract more investors in the CDC portfolio. While the members cannot lobby specifically as a committee member, they are not prohibited from doing so as individuals, using the information that they have. However, it was also commented that individuals can distract from the efforts of lobbying organizations. *Mr. Delaney agreed to work with CDC Counsel to send relevant explanatory materials on lobbying out to the members.*
- The total of CDC capital improvement program is ~\$250 million annually, but that can fluctuate.

Dr. Snider restated his query about this committee's role as an external oversight mechanism for the Office of Public Health Research, specifically in developing the CDC research agenda. Relevant options included doing this as a chartered federal advisory committee. This could establish subcommittees or workgroups staffed by committee members and invited experts. These would report their recommendations back to the parent committee which would in turn advise CDC. Some members might have to report conflict of interest, if the general areas of research discussed could benefit them (financially or professionally) or the institution for which they worked. However, Dr. Snider expected that the discussions would be broad and unlikely to be that specific. Several members indicated their interest in working on this subcommittee or workgroup. A later conference call could be arranged to discuss the related issues in more depth. *Mr. Delaney agreed to provide for the members the various options that might frame this work*

before September

### ***Terrorism Preparedness***

Presenter: Mr. Charles Schable, Director, Office of Terrorism Preparedness and Emergency Response (OTPER)

CDC's community preparedness goal is to minimize the health consequences from acts of terrorism or other public health emergency. The four program goals include: 1) strategic preparedness planning and evaluation; 2) incident detection and notification; 3) control, containment and response to an event; and 4) support of state and local preparedness.

In 2004, CDC funded ~\$102.4 million for strategic preparedness planning and evaluation, resulting in 39 projects with 7 measures; ~\$85 million for incident detection (31 projects, 7 measures), and ~\$42 million for control, containment and response (10 projects, 3 measures). An additional \$938.5 million was spent to support state/local preparedness (7 projects, 7 measures).

The Emergency Preparedness Grant Program involves 62 grantees who have received \$2.7 billion since FY02 (additional HRSA grants raise that to \$3.7 billion). The cooperative agreement, now in year 5, supports >3500 people nationally, working full- or part-time on preparedness. The grants are one of the top three funding sources for state health departments. This Program has nine project officers with subject matter experts spread throughout CDC's CIOs.

The definition of "emergency preparedness" varies between the states, and "more work is needed to keep 'emergency' in 'emergency preparedness.'" Even as considerable as the preparedness funding is (\$3.7 billion), it is not sufficient for the state health departments to ensure 100% emergency response in addition to conducting all their normal work. The new cooperative agreement now in development will base the performance indicators and goals on research, evidence, and best practices, that are particular to that state/locale's public health department needs. Time lines for this new grant were outlined, up to its award releases on July 1, 2005. That overlaps the termination of the original grant by a few months to ensure the continuity of the process.

OTPER has been successful in implementing the Laboratory Response Network (LRN) of integrated national and international labs. They are ready to respond not only to terrorism events but also to emerging public health threats and emergencies. They share common reagents, protocols, etc., to ensure the reliability of test results between labs. The LRN began in 1999 with 61 labs and now has 123. More involvement of food, veterinary, clinical and commercial national testing laboratories is needed, as is more standardized electronic lab reporting systems.

The NCIH and ATSDR labs serve as a national (and perhaps global) reference lab. Their Rapid Toxic Screen can identify ~150 chemical agents and their metabolites. They can evaluate whether increased levels in people resulted from elevated environmental levels, to what agents people were exposed, and at what levels they absorbed it. The measurable agents, chemical warfare agents, biotoxins, incapacitating agents, and industrial chemicals, were listed. However, this ability is not mirrored nationally. Sixty-two labs of the LRN that have a response plan in place for chemical competency but only for the collection and shipment of specimens. Another 41 labs can conduct Level 1 activities and can test for cyanide and toxic metals. Five can do that and also test for mustards and nerve agents. More work on chemical testing is underway, but it is complex work requiring expensive instruments such as mass spectroscopy.

Dr. Gerberding emphasized that this is a critical unmet capacity in our nation. The surge capacity that would be needed upon an event is nonexistent; testing demanded by the worried well along with those exposed would quickly overcome the system. A very cogent message about the criticality of this need is necessary and is being developed at the White House level.

Finally, Mr. Schable outlined CDC's Cities Readiness Initiative (CRI). It involves 21 large cities, which were selected based on threat analysis, capability of response, and other factors. The sites were mapped. The CRI is designed to ensure that needed drugs could be dispensed within 48 hours of a decision to do so. The CRI is housed in and run by the Strategic National Stockpile Program. The CRI involves many partners: state and city health departments and even the U.S. Postal Service. Current plans are felt to be inadequate, as widespread dispersal of agents by terrorist groups to cause widespread loss of life is possible. An inhalation anthrax scenario drives the CRI strategy, since action must be taken within 48 hours of exposure, long before those exposed become symptomatic.

*Discussion included:*

- OEPER's emergency response capability is only two years old, and has grown from one person to a staff of >200. Its value was demonstrated last year in its concurrent response to the monkey pox and SARS outbreaks, involving 150 people working around the clock at the Emergency Operations Center.
- An event could be recognized as an environmental event by BioWatch. Dr. Gerberding asked the committee's advice on how to create the proper expectation among the public of what is likely to happen in any sizable bioterrorism release. For example, an anthrax release in a BioWatch city would allow CDC to model the plume of exposure and try to reach those exposed based on that – but not with much precision, and a second release could not be ruled out. The public has to understand that the responding agencies could only do the best they can, and that as with the anthrax attacks, the signal might be missed until ER patients present. The intense work to prepare as much as possible also risks inviting a false sense of security in the public.
- Dr. Jappin asked for a *presentation at the next meeting of the gap between present*

*response capacity, what a responsible (not perfect) response level would be, and what is needed to fill that gap.* It would be a phenomenal challenge to reach everyone in a large city, including the homeless. Very few cities could get antibiotic prophylaxis out within 48 hours to even a defined group of people. Options that may be considered to reduce the response time include pre-deploying emergency antibiotics to the nation's homes.

- The 12-hour push-pack time window is also too late. Dr. Galli noted, to distribute prophylaxis for a nerve agent attack. Dr. Gerberding reported that the 48-hour response plan is based on aerosolized anthrax. There is no scenario for a nerve agent attack other than having an antidote in every home. But fortunately, a mass nerve agent exposure is an unlikely scenario.
- Dr. Frieden stated that there can be no zero risk situation. Even environmental monitoring is unlikely to identify the most likely areas of risk. The awareness of primary care providers about what is happening on a real-time basis will be essential to response. In 1947, it was proven that 6.3 million people could be vaccinated against smallpox. At least that, and perhaps much more, can be done now.
- Dr. Benjamin raised the legal aspects of distributing prophylaxis, but field testing can reduce the administrative burden. For example, during the anthrax events, Washington D.C. used their STD clinics to administer Cipro. The problem remains getting the drugs out.

### ***BioSense Program***

Presenter: Dr. John Loonsk, Acting Director, National Center for Public Health Informatics

Informatics includes a wide range of activities, from disease surveillance, to delivery of information and to countermeasure response administration. The BioSense Initiative is designed to enhance early detection and to support information needs after an initial bioterrorism event is identified: its size, location, and support the response management needed. BioSense is both a system and an initiative, in that it is an important step towards the development and implementation of real-time national surveillance infrastructure, its broad goal.

Traditional case reporting is a challenge to computerize. It is most usually dependant on being initiated by a clinician who identifies a case that meets certain criteria, and then calls in, writes it down and mails it, or possibly posts a report to a web page. The critical factor is that it must be initiated, meaning that many reportable disease cases are not actually reported. It can take as long, in the extreme, as 26 days for a report, even of a bioterrorism agent, to be received at CDC. Other than timeliness, reporting also involves issues of identifying events across jurisdictions.

BioSense involves the secondary use of data, mostly healthcare data resources, to avoid the need for an initiating report. It supports early event detection through accessed and analyzed pre-existing data sources such as diagnostic and pre-diagnostic health records (e.g., diagnoses from

ambulatory, clinical or tertiary care settings). These can provide good early indicators to detect and quantify the extent of an outbreak. As the electronic patient record grows, such data will be even more easily shared with public health. Other data source opportunities also exist that could indicate an outbreak, such as OTC drug sales or school absenteeism. One problem with them is that there is no real opportunity for secondary investigation to follow up on data anomalies or naturally occurring signals, as would be done by traditional surveillance. BioSense is focusing on using substantiated clinical data now and evaluating these other promising data sources for their utility.

The BioSense view for the city of Atlanta was shared. The display showed, at the top, algorithmic analysis of data entering the system compared to expected levels in this particular area and time period, both temporally and by location (e.g., the color blue would indicate the need for investigation). The system allows further delineation to determine if the effect seen is simply a data anomaly. The data can also be tracked over time to help determine how to manage the response. Another BioSense data time series data visualization geographically charted the presentation of different syndromes, as well as more detailed description of specific occurring health events. The reporting depended on the medical record system's capacity to move from population data to more specific data.

The academic community has become interested in Public Health Informatics specifically to determine how to detect an initial event among a series of data. Public health is also interested in the ensuing events: subsequent detection, quantification, localization of an event, and its management (e.g., information systems were shown to be helpful to contact tracing in the Toronto SARS outbreak). Such data need to be related to lab results that confirm cases, and to countermeasure administration.

The Public Health Information Network (PHIN) is working to seamlessly link these systems to provide such information and capabilities. BioSense is a major part of PHIN and the DIIHS-DIIS 2005 biosurveillance initiative that includes other projects, BioShield (rapid development of new vaccines/therapeutics) and BioWatch (environmental air samplers deployed in key locations). It is the health "sector" of the surveillance architecture, along with enhanced quarantine stations and real-time LRN electronic data communication. Other "sectors" have enhanced surveillance (e.g., of water, agriculture, etc.). Linking those sectors to the human health focus monitored by CDC to allow data analysis will allow comparison with intelligence data at the Department of Homeland Security.

The current status of BioSense includes municipal-level analysis of all the BioWatch cities, analyses for every state, users in all the states and BioWatch cities, and a CDC BioIntelligence Center that reviews and analyzes data and works to support others analyzing data. Work is beginning to prototype the delivery of jurisdictional data, targeting a number of data sources. Any data used in the BioSense system also will be provided to the states and cities for their own

use

Future plans include work to enhance the sensitivity and specificity of the data collected. That will require development of "test beds" and advancing the data exchange capabilities. All of this is done without using patient names or medical record numbers in the reported data so as to protect patient privacy.

*Discussion included:*

- Mr. Smith asked why personal identifiers are not used. Dr. Loonsk cited privacy issues, which prompted this compromise to balance those rights while still enabling appropriate public health follow-up.
- Dr. Mahkorn appreciated the use of existing databases rather than creating new ones, which avoids adding to clinicians' reporting burden. She also suggested that insurance claims data be used, whose timeliness Dr. Loonsk said was improving.
- Dr. Frieden was concerned at the mention of "national real-time surveillance architecture," in which local and state health authorities and CDC are the building blocks. He noted that most outbreaks were identified by alert clinicians. That is likely to continue in the future, and the relationship with the local provider should not be interrupted. He also cited the peculiarities of local reporting relative to setting off a data alarm (e.g., one area clinician may "specialize" in diagnosis of a particular syndrome). Dr. Loonsk agreed that the clinician will frequently remain the detector, but there are many needs after initial case reporting. These tools are meant to be complementary, not to supplant case reporting and the promise has been demonstrated of looking across health care settings to review initial trends that would not have been obvious to the initial clinician.

**Public Comment.** Comments were solicited, to no response.

**Closing Comments.** Dr. Gerberding thanked the committee for their attendance and input. She invited them to communicate with her by e-mail at any time, all of which she reads. Communication to the members would be done on the committee's advisory role and on the participatory process of developing CDC's research agenda. With her thanks and that of Dr. Agwunobi, the meeting ended.

**ATTACHMENT: ATTENDANCE, Advisory Committee to the Director (ACD) Meeting**

*Julie T. Gerberding, M.D.*, Director, CDC

*Robert Delaney*, Executive Secretary, ACD and Chief of Staff, CDC

**Members present:**

*John O. Agwumobi, M.D., M.B.A., M.P.H.*, ACD Committee Chair, Secretary of Health and State Health Officer, Florida Department of Health, Tallahassee, FL

*Joel Reed Bender, M.D., Ph.D.*, Corporate Medical Director, General Motors Corporation, Detroit, MI

*Georges C. Benjamin, M.D., F.A.C.P.*, Executive Director, American Public Health Association (APHA), Washington, D.C.

*Marilyn M. Billingsly, M.D.*, Professor of Internal Medicine, Associate Professor of Pediatrics, Associate Director, Internal Medicine – Pediatrics Residency Program, St. Louis University, St. Louis, MO

*Mary desVignes-Kendrick, M.D., M.P.H., F.A.A.P.*, Professor-Management, Policy and Community Health; Deputy Director – Center for Biosecurity and Public Health Preparedness, UT Health Science Center at Houston, School of Public Health, Houston, TX

*Thomas R. Frieden, M.D., M.P.H.*, Commissioner, New York City Department of Health and Mental Hygiene, New York, NY

*Robert L. Galli, M.D.*, Professor and Chair, Emergency Medicine, University of Mississippi Medical Center, Jackson, MS

*Debra Lappin, J.D.*, Senior Advisor, B&D Sagamore, Washington, D.C.

*Sandra K. Mahkorn, M.D., M.P.H., M.S.*, Chief Medical Office, Division of Health Care Financing, Wisconsin Department of Health and Family Services, Madison, WI

*Joe S. McIlhenny, M.D.*, Founder and Chairman, The Medical Institute for Sexual Health, Austin, TX

*Shepherd Smith*, Founder and President, The Institute for Youth Development, Sterling, VA

*Antronette K. Yancey, M.D., M.P.H., F.A.C.P.M.*, Associate Professor, University of California in Los Angeles, School of Public Health, Los Angeles, CA

**Members Absent:**

Joseph M. Hogan, President and CEO, General Electric Healthcare Technologies, Waukesha, WI

Alexander R. Lerner, Executive Vice President and CEO, Illinois State Medical Society, Chicago, IL

CDC staff present:

Ileana Arias  
Stephen Blount  
Steve Boedigheimer  
Kristin Brusuelas  
Thayes Carswell  
Mitchell Cohen  
Harold (Skip) Connett  
Jeff Cook  
Glen Coops  
Audria Dunson  
Jim Down  
Thena Durham  
Henry Falk  
Joe Henderson  
Barbara Holloway


John Howard  
James Hughes  
Dale Hubbard  
Doresa Jennings  
Muin Khoury  
Paula Koehler  
John Loonsk  
Betty Loy  
Sharon Mahone  
James Marks  
David McQueen  
Gaylon Morris  
Lydia Ogden  
Brad Perkins  
Harald Pietz

Ken Rose  
Michael Sage  
Ed Sondik  
Charles Schable  
Suzanne Smith  
Dixie Snider  
Robert Spengler  
Edward Stehmeyer  
Karen Steinberg  
Stephen Thacker  
Ed Thompson  
Marsha Vanderford  
Melinda Wharton  
Walter W. Williams

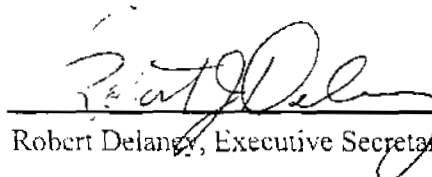
Members of the public:

Ed McBrayer, PATH Foundation, Atlanta, GA

I hereby certify that the foregoing summary of the Advisory Committee to the Director, Centers for Disease Control and Prevention (CDC) meeting held on Thursday, August 5, 2004 is accurate and complete to the best of my knowledge.

  
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John O. Agwunobi, M.D., M.B.A., M.P.H., Chairman

10/28/04  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Robert Delaney, Executive Secretary

12-17-04  
\_\_\_\_\_  
Date